

From: Kevin Bampton

Sent: Friday, June 27, 2025 10:05 AM

To: Ashley Dalton MP; dhsc.publicenquiries@dhsc.gov.uk

Cc: Wes Streeting MP; appg.longcovid@longcovid.org; Tim Farron MP; D Whyms; Andrew Curran

Subject: RE: Letter to Ashley Dalton from Covid Transmission Alliance

Dear Minister,

I hope you are well and imagine that you will be looking forward to a well-earned Summer recess.

I write to respectfully advise that CATA (the representative organisation for 65,000 experts, professionals and healthcare workers) has still not received either a holding reply or a substantive response to our correspondence. In it we pointed out material inaccuracies in letters sent by your Department to Tim Fallon MP and Andrew George MP on COVID-19 transmission. CATA's leading expertise in this area was recognized by being granted Core Participant status for Module 3 of the ongoing COVID-19 Inquiry. (You may wish to draw your Department's attention to [Guide to Handling Correspondence - GOV.UK](#))

I have been asked to follow up on this on behalf of CATA.

While concerns about the effective control of the airborne route for COVID-19 transmission may seem an academic issue of the past, we continue to collate ongoing data and reports of vulnerable healthcare workers suffering long term and debilitating illness as a result of inadequate control. We will particularly draw your attention to risks in the context of maternity care, for example.

Failure to adequately control exposure of healthcare workers to respiratory pathogens, including COVID-19, is having a direct service impact on staffing and resources, as well as being a significant patient safety issue. We believe that your correspondence demonstrates that you have been incorrectly advised and that therefore policy directions which fall within your remit will be tainted by irrelevant considerations and the failure to take into account relevant considerations.

We have highlighted before that WHO provides a risk methodology which is binding on the UK for the determination of airborne transmission risk. As we previously advised, the UK Government has clearly stated the requirements for safe working (which supersede the links referred to in your correspondence). This guidance is still scientifically valid to reduce airborne transmission where it presents a significant risk to workers. The prevention of ill-health in the workplace resulting from exposure to hazardous biological substances may be a service concern for organisations subject to CQC through IPC guidance. However, preventing exposure of workers to hazardous biological pathogens is directly regulated by the Control of Substances Hazardous to Health Regulations 2002. Breach of COSHH is a criminal offence, not merely something that can have a negative CQC inspection outcome.

On March 22 2022, at the Chief Scientific Advisers' National Core Study – Transmission Update meeting, the importance of protection against airborne transmission of COVID-19 was outlined to all Government scientific advisers by Professor Andrew Curran (copied for confirmation). He went on to reinforce that droplet precautions were insufficient to protect against the aerosol component of COVID-19 transmission. We have copied our message to him, so he can directly confirm to you that airborne transmission is a material transmission route associated with COVID-19 infections and that droplet-based precautions would be insufficient to protect against the aerosol element of COVID-19 transmission.

We have also been made aware that, based on PHE and UKHSA's view that surgical masks are as effective in the control of respiratory diseases (even if they have an airborne element) there is diminished use of respirators (such as FFP3s) for the treatment of patients with other airborne diseases. Airborne diseases such as Scarlet fever and Tuberculosis are on the increase and there is currently no systematic process for monitoring airborne nosocomial infection rates. We counsel that the ongoing ambiguity about the transmission routes for COVID-19 and the retreat from HSE's firm guidance on the correct RPE for control of airborne infections poses a continuing and future risk across the range of airborne infections.

We also respectfully believe that the incorrect scientific position you and your predecessor outline in correspondence is likely to directly be inducing NHS employers in England and Wales to act in breach of Health and Safety law. We are aware that the role of DoH/PHE/UKHSA in directing employers to avoid scientific evidence of airborne transmission is also the premise of NHS employer defence to current claims currently before the High Court, redirecting liability to your Department. The inaccurate statements in your correspondence, if they stand uncorrected, would appear to support that proposition by running counter to the established scientific evidence needed to prevent ongoing instances of death or injury of healthcare workers as a result of exposure to a hazardous airborne biological pathogen.

As we previously pointed out, in letters to Tim Fallon MP and Andrew George MP, you and your predecessor have been directed by your Department to refer to advice which is inconsistent with:

- UK Government policy;
- the findings of the National Core Study;
- the evidence provided to the COVID-19 Inquiry by UKHSA under oath;
- published guidance; and
- the WHO's position.

The latest edition of the CDC Yellow Book [COVID-19 | Yellow Book | CDC](#) provides a clear outline of the currently accepted scientific evidence:

“SARS-CoV-2 is transmitted from person to person by airborne particles and droplets that carry infectious virus. When an infected person breathes, sings, talks, coughs, or sneezes, they release infectious aerosol particles into the air. Exposure can occur when aerosol particles and

small respiratory droplets are inhaled or contact exposed mucous membranes. Indoors, fine droplets and aerosol particles can linger and accumulate, even after an infected person has left the room. The risk of infection generally increases with closer contact and with longer durations of contact with an infected person, particularly in poorly ventilated indoor or crowded settings. Activities that increase emission of respiratory fluids, such as singing, cheering, or exercising, can increase risk of transmission. Infection from contaminated surfaces or objects is possible but generally does not contribute significantly to new infections.”

In the absence of an explanation or correction, it would therefore appear that the Department is proceeding in breach of public law. **Our next step, if no substantive response is received, is to take is to prepare a pre-action letter to initiate judicial review proceedings against you,** the Department and related public bodies.

We are aware of the demand, expense and inconvenience caused by judicial review procedures, even at pre-action stage. It would also be an unwelcome drain on our resources. We would therefore urge the Department to provide a substantive and properly reasoned explanation, in the context of all current Government scientific data (not just NHS internal publications and reviews), applicable law (in addition to general policy statements) to avoid having to initiate a Judicial Review process.

Every effort in such a response should be made to avoid defaulting to general policy statements, avoiding answering our legitimate scientific and regulatory questions or to digress, as have been features of previous correspondence received by MPs.

To aid the correspondence team, the response should answer the following questions at the very least:

- 1) Upon what current, peer reviewed scientific evidence does DHSC rely for you to state that airborne transmission is not a route that requires protection against to stop infection of healthcare workers in line with COSHH? (Note vaccination does not prevent infection or re-transmission). New evidence would be required to justify a departure from the evidence given by State witnesses about the current scientific thinking on transmission? Only one State witness to the COVID-19 Inquiry, Dr Lisa Ritchie, stated a view that airborne transmission was not an infection route, having also stated that her role was not to determine the science, but to implement the scientific findings of others. Is the Department’s view entirely based upon Dr Lisa Ritchie’s opinion? Did State witnesses misrepresent current Government thinking to the Inquiry, since what you say in your letter is incompatible with evidence presented there under oath.
- 2) In the absence of new, peer reviewed evidence, why is DHSC failing to ensure that UK health bodies are properly directed as to the hazard and risk to protect workers and patients in line with the Health and Social Care Act 2008 and, more importantly, in line with COSHH?

Professional health bodies (such as CATA members) are here to support and promote the important work of government in securing the health of the nation. Each of them works daily to try and support the health of the nation and a better understanding of the scientific evidence base. Your advisers are legally required to do the same. Following well-established science and effective infection prevention and control methods to protect healthcare workers, is essential to do this. As you know and are committed to, maintaining policies in line with developing epidemiology is at the heart of effective healthcare. The transmission routes for COVID-19 are not a legal and academic issue of the past, but are relevant to current and immediate Government health priorities.

For example, the impact of COVID-19 infections on pregnant women and the unborn child are well-recognised. Vaccinated healthcare workers can still transmit the virus to pregnant women and babies. Management of COVID-19 in maternity care therefore has a direct impact on maternity outcomes. The failure to understand routes to transmission in maternity units (which are already subject to investigation by the HSE in relation to ventilation control) will negatively impact maternity outcomes and care. It would be unfortunate if that absence of up-to-date scientific knowledge in your Department were to be contributing to higher mortality rates for mothers and higher levels of premature births and infant mortality. [COVID-19 and Pregnancy | RCOG](#). We know the Government is concerned about the failure of maternity care in the UK and would be surprised if the Department is willing to contribute further to that failing by failing to follow the current (internationally accepted) scientific position.

Our correspondence seeks to be helpful to you, personally, to ensure that you are being correctly advised. The prospect of judicial review is an act of desperation on our part as we seek to help you to help us work together to keep our healthcare workers and people safe.

We would be delighted to positively assist with how healthcare workers can be effectively protected from infection by COVID-19 and other airborne pathogens which cost the NHS hundreds of millions in lost hours and agency costs each year. This would be a more fruitful use of our expertise than instructing lawyers in order to resolve issues arising from what I am sure it merely bureaucratic inefficiency in your Department.

We would be delighted to meet with you to discuss this matter, of that is more helpful. CATA comprises the country's leading experts in this field and also works with the support of RCN, BMA and a number of significant professional bodies.

All the best,

Kevin

Kevin Bampton

Chief Executive Officer

From: Kevin Bampton

Sent: Tuesday, March 18, 2025 10:44 AM

To: Ashley Dalton MP; dhsc.publicenquiries@dhsc.gov.uk

Cc: Saunders Law; GA Solicitors; Bond Turner; Sir Stephen Timms MP; Wes Streeting MP; appg.longcovid@longcovid.org; Tim Farron MP

Subject: Letter to Ashley Dalton from Covid Transmission Alliance

Dear Minister,

Please find attached urgent correspondence for your attention in respect of your recent reply to Tim Farron MP.

Yours sincerely,

Kevin Bampton

Professor Kevin Bampton

Chief Executive Officer



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